chase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other Federal or state law or regulation such as Certificate of Need.

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims and necessary

and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C), the interest associated with the portion of the loan or loans which exceed the asset cost basis as defined in subsection (7)(C) shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

10. A provider shall amortize finance charges, prepaid interest and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if such capital expenditure fails to comply with other federal or state law or regulations such as Certificate of Need.

(E) Rental and Leases

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas provided that the rented items are necessary

and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and lease amounts, except in the case of related parties which is subject to other provisions of this plan, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to Certificate of Need approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program, shall be a non-allowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing or refunding operations such as taxes on the issuance of bond, property transfer, issuance or transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which is not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment (FICA) taxes applicable to individual proprietors, partners or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compen-

sation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities shall also be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost area, provided that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(I) Fringe Benefits

1. Life Insurance

A. Types of insurance which are not considered an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where, insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction, and upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area --

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement Plans

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners and proprietors of the provider shall be allowable cost areas. Interest income from funded pensions or retirement plans shall be excluded from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred Compensation Plans

A. Contributions for the benefit of employees, excluding stockholders, partners and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include travel costs incidental thereto but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to states of incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off such costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to his entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty (60)-month period.

6. For change in ownership, after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods or services obtained elsewhere. In the uniform cost report a provider shall identify suppliers related to it and the type-quantity, and costs of facilities, goods and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX recipient. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of reimbursable recipient days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%) the following cost centers will be calculated as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general and administrative and plant operation costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Nonreimbursable Costs

1. Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and Medicaid must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of social services provided under contract or subcontract is specifically excluded as an allowable item.

6. Any costs of litigation or attorneys' fees incurred by a provider of service shall not be a reimbursable cost except to the extent permitted by this part or other specific provisions of the regulation. Cost of litigation against the state, including attorneys' fees, when the litigation is reasonably related to the care of recipients and the provider prevails, are reimbursable costs. Attorneys' fees incurred in labor negotiations, and labor disputes are reimbursable. All of the attorneys' fees except those allowed by specific provisions of this regulation are non-reimbursable costs.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost, and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue; income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than recipients; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this regulation. Failure to separately account for any of the foregoing specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided such interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider, paragraph (7)(R)3. of this section, shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds -

A. Restricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes and income from endowments, which must be used only for a specific purpose designated by the donor.

Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the funds will not be offset from total allowable expenses.

B. Unrestricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this rule are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local or local-to-local provider. These funds are not considered a grant or gift for reimbursement purposes, thereby having no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to Medicaid Recipient Residents

1. A provider's allowable cost areas shall be apportioned between Medicaid program recipient residents and other patients so that the share borne by the Medicaid program is based upon actual services received by program recipients.

2. To accomplish this apportionment, the ratio of recipient residents' charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for Medicaid program recipient residents determined on the basis of a separate average cost per-diem for general routine care areas or at the option of the provider on the basis of overall routine care area.

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing these services.

4. Average cost per-diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

5. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this regulation, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a recipient is away from the facility on

a facility sponsored group trip and remains under the supervision and care of facility personnel.

6. ICF/MR facilities that provide Intermedicare Care Services to Medicaid recipients may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities as management services, dietary, housekeeping, building maintenance and laundry.

7. In no case may a provider's allowable costs allocated to the Medicaid program include the cost of furnishing services to persons not covered under the Medicaid program.

(S) Return on Equity

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall not exceed twelve percent (12%).

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, propriety and equipment (cost of land, mortgage payments toward principle and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program reimbursable recipient resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(8) Reporting Requirements

(A) Annual Cost Report

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.

2. Unless adequate and current documentation in the following areas has previously been filed with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all manage-

ment contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. Following the ninety (90)-day period, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the payments that were withheld will be released.

5. If requested in writing, a thirty (30)-day extension of the filing date may be granted for good cause shown.

6. The termination of or by a provider of participation in the program or a change of ownership requires that the provider submit a cost report for the period ending with the date of termination or change. The cost report is due within forty-five (45) days of the date of termination or change. Cost reports under this paragraph shall conform to the principles of section (7). The final payment due providers shall be withheld until their cost report is filed.

(B) Certification of Cost Reports

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make such certification and will furnish proof of such authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification Statement

Form of Certification

Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by _____ (Provider's Name(s) and number(s)) for the cost report beginning _____ and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature	Title	Date

(C) Adequacy of Records

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services, at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions stated in section (8) of this rule or other sanctions available in section (9).

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(E) Audits

1. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve (12)-month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department will conduct a desk review of all cost reports within six (6) months after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

5. The department shall retain the annual cost report and any working papers relating to the audits of these cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed-days or certified beds of greater than sixty percent (60%) and/or an annual Title XIX payment of two hundred thousand dollars ($200,000) or more shall be required, for at least the first two (2) fiscal years of partic-

ipation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

(9) Sanctions and Overpayments

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 of the Missouri Code of State Regulations and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(10) Exceptions

(A) For those Medicaid-eligible recipient-patients who have concurrent Medicare Part A skilled nursing facility benefits available, Missouri Medical Assistance program reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located; and

2. For providers which provide services of one thousand (1,000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of --

A. The rate paid for comparable services and level of care by the state in which the provider is located; or

B. The rate calculated in sections (4) and (6) of this rule.

(11) Payment Assurance

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these regulations.

(B) Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for

remitting third-party payments are provided in the Missouri Medical Assistance program provider manuals.

(12) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(13) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable co-payments.

(14) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

APPENDIX: ROUTINE COVERED
MEDICAL SUPPLIES AND SERVICES

ABD Pads

A&D Ointment

Adhesive Tape

Aerosol Inhalators, Self-Contained

Aerosol, Other Types

Air Mattresses, Air P.R. Mattresses

Airway-Oral

Alcohol

Alcohol Plasters

Alcohol Sponges

Antacids, Nonlegend

Applicators, Cotton-tipped

Applicators, Swab-Eez

Aquamatic K Pads (water-heated pad)

Arm Slings

Asepto Syringes

Baby Powder

Bandages

Bandages-Elastic or Cohesive

Bandaids

Basins

Bed Frame Equipment (for certain immobilized bed patients)

Bed Rails

Bedpan, Fracture

Bedpan, Regular

Bedside Tissues

Benzoin

Bibs

Bottle, Specimen

Canes

Cannula-Nasal

Catheter Indwelling

Catheter Plugs

Catheter Trays

Catheter (any size)
Colostomy Bags
Composite Pads
Cotton Balls
Crutches
Customized Crutches, Canes and Wheelchairs
Decubitus Ulcer Pads
Deodorants
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressings (all)
Drugs, Stock (excluding Insulin)
Enema Can
Enema Soap
Enema Supplies
Enema Unit
Enemas
Equipment and Supplies for Diabetic Urine Testing
Eye Pads
Feeding Tubes
Female Urinal
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Folding Foot Cradle
Gastric Feeding Unit
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hand Feeding

Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Infusion Arm Boards
Inhalation Therapy Supplies
Intermittent Positive Pressure Breathing Machine (IPPB)
Invalid Ring
Irrigation Bulbs
Irrigation Trays
I.V. Trays
Jelly-Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap and Oil
Male Urinal
Massages (by nurses)
Mathiolate Aerosol
Medical Social Services
Medicine Dropper
Medicine Cups
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gatric Tubes
Nasal Tube Feeding
Nebulizer and Replacement Kit
Needles (various sizes)
Needles-Hypodermic, Scalp, Vein
Nonallergic Tape
Nursing Services (all) Regardless of level including the administration of oxygen and restorative nursing care

Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)
Overhead Trapeze Equipment
Oxygen Equipment (such as IPPB Machines and Oxygen Tents)
Oxygen Mask
Pads
Peroxide
Pitcher
Plastic Bib
Pump (Aspiration and Suction)
Restraints
Room and Board (semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Sheepskin
Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Stomach Tubes
Stool Softeners, Non-legend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including Sterile Sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, Disposable
Tape-For Laboratory Tests
Tape (nonallergic or butterfly)
Testing Sets and Refills (S & A)

Tongue Depressors

Tracheostomy Sponges

Tray Service

Tubing-I.V. Trays, Blood Infusion Set, I.V. Tubing

Underpads

Urinary Drainage Tube

Urinary Tube and Bottle

Urological Solutions

Vitamins, Nonlegend

Walkers

Water Pitchers

Wheelchairs